UNIVERSITY of MARYLAND
MEDICAL SYSTEM

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CORPORATE OFFICE

Memorandum

Date: August 31, 2017

To: Maryland Rural Study Work Group

From: University of Maryland Medical System
University of Maryland Shore Regional Health

Re: Observations and Response to Work Group Recommendations

Our thanks to the Rural Study Work Group for the months and hours of study, discussion and thoughtful recommendations regarding the unique challenges of providing access to quality, patient-centered and cost effective health care in vulnerable rural communities.

We offer special recognition to the leadership of the rural study process, particularly Senator Mac Middleton, co-chairs Deborah Mizeur and Joseph Ciotola, MD, Secretary Dennis Schrader, and MHCC Executive Ben Steffen. The MHCC staff of Erin Dorrien and Kathleen Ruben have been especially helpful.

First and foremost, please know that UMMS and UM Shore Regional Health take very seriously the responsibility and commitment, outlined in the recommendations, to collaborate with community health care partners and to engage with, listen to and be responsive to input from these partners and the wider regional community. Our commitment to the Work Group, to our elected officials and this community is to be diligent and comprehensive in this responsibility. To that end, and as evidence of our serious intentions and responsiveness to issues of community input in the UM Shore Regional Health discussions and planning, we hereby make the following commitments:

- To hold an annual consumer-focused health care listening session in each of the five counties we serve, for the purpose of hearing the public's issues and soliciting feedback;
- To explore engaging an elected official from the five county region in UM SRH governance;
- To work with the regional Local Health Improvement Coalition (LHIC) and the public, as part of participation in LHIC meetings, to identify and prioritize community health needs and services; and
- To appoint a citizen representative from each of the five counties in this region as a member of the Board Strategic Planning Committee.

The Rural Study Work Group document is an exceptionally well-done set of recommendations and we are pleased to have been a part of its development. As detailed in the attached response, we support essentially all of the recommendations, with questions for clarity and only one recommendation which we believe requires further review (see 2 below).

What follows this memorandum, added in sequence with the Work Group recommendations and highlighted in yellow, are the observations and responses of our health system to the work group recommendations that were issued as a draft for review in July, 2017 and revised/reissued on August 18, 2017. The addendum further ranks the recommendations of UMMS and UM SRH in priority order and cross-walks those recommendations to the work group's recommendations. We call your attention to several issues which arise for us in the workgroup's documents and suggest your consideration of these issues in your continued discussions and final report to the General Assembly:

1. A priority concern for UMMS/ UM SRH is the revised hospital rate structure necessary in support of the recommendations, particularly those revolving around the rural community health complex facility levels as well as the recommendation for a new designation of special rural community hospital. This must be strengthened in the recommendations.

2. We do not support the concept of additional levels of "governance" and the overlaying and integrating of this "governance" with the existing Boards of existing health care partners. Such a structure is impractical, duplicative and cumbersome. A more effective and appropriate council might be defined as an "Advisory Council."

3. Not addressed in these recommendations is the issue of competition for the "profitable" aspects of health care, leaving vulnerable rural communities to hold together the essential services without the full benefit of those resources taken out of the community by competing entities. This issue should be addressed in the recommendations.

4. The work group recommendations are not described in priority order. As a result, we have included an addendum in our responses which defines what we believe to be the order of priority and cross walks this list to the recommendations in the workgroup report. We ask that the workgroup recommendations be amended to this priority order.

We appreciate the opportunity to review and comment on the initial report of the Rural Study Work Group. As the regional health care system serving the five county region of Maryland's Eastern Shore, we stand ready to work collaboratively with the leadership of the rural study to identify those recommendations that we, UMMS and UM Shore Regional Health, should assume responsibility for and to implement those recommendations as our priorities.

Sincerely,

Robert A. Chrencik, President and CEO
University of Maryland Medical System

Kenneth Kozel, CEO
UM Shore Regional Health

UMMS/UM SHORE REGIONAL HEALTH

REVIEW OF RURAL STUDY WORKGROUP RECOMMENDATIONS AND SUGGESTIONS FOR PRIORITIZATION

August 31, 2017

Draft Recommendations revised as per the Workgroup meeting July 25th, 2017:

The Rural Health Work Group's vision is a model of healthcare delivery that provides seamless, integrated care to patients living in rural communities, as close to their homes as possible. A rural community health complex demonstration project would enable better integration of services and coordination among providers. Our report covers recommendations that facilitate patient access to appropriate levels of care on a timely basis through expanded collaboration and planning; attract primary care providers to rural areas through increased incentives; enhance and integrate behavioral health services to deliver more collaborative care; provide new opportunities for care in the home that address the needs of the chronically ill; and improve access to specialty services at the local level. Rural Maryland communities will need new funding to establish and sustain the initiatives that are proposed in the recommendations in our report. To the extent possible, the Workgroup recommends that existing infrastructures, including Local Health Improvement Coalitions and Local Health Departments, serve as the entities responsible for guiding establishment setting standards and measuring success.

1. Establish and Support a Rural Community Health Complex Demonstration

The Workgroup recognizes that health care systems of the future need to accommodate a culturally diverse population, as well as a growing number of vulnerable and elderly residents with chronic health conditions. Recognizing and addressing the social determinants of health is crucial in promoting a healthy society. Stakeholders must support an integrated care delivery system that promotes health equity, quality, and comprehensive services across a continuum of care. The Workgroup has established principles to guide its work. These principles are integrated into the vision of the Rural Community Health Complex model.

The Rural Community Health Complex is the center for health care delivery in a rural community. A complex is sized to respond to the needs of the population, the scope of services that can be supported in the immediate community, and proximity to other health care complexes in surrounding communities, the jurisdiction, and the region. The foundation of any Rural Community Health Complex is primary care. Rural Community Health Complexes would have a governance council made up of top level representatives of hospitals, practices participating in the complexes, local health departments, and consumers, to plan deployments, distribute resources, and resolve integration problems.

Goals

- Better integrate existing government services and clinical services for improved outcomes, patient convenience, and satisfaction; as well as less duplication, for overall lower cost.
- Better integrate primary care with behavioral health and dental services.
- Decrease transportation needs as multiple appointments/services can be managed with the same trip. Specialists are brought onsite so that patients don't have to travel long distances.
- Decrease medically unnecessary Emergency Department use.

- Create a community of wellness.
- Bring care as close to the patient as possible.
- Increase care coordination and information sharing among providers to achieve safer and more effective patient-centered care.
- Increase patient education and outreach to improve health literacy, encourage wellness, and improve outcomes.

RESPONSE: UMMS/UM SRH support the concept of an integrated delivery system, involving all regional health related organizations, that enables the development of healthier citizens and communities. The development of initiatives that support a Rural Community Health Complex should, we agree, be funded as a demonstration project and therefore, may or may not be an actual physical location; rather, it may need to be a "virtual complex" of coordinated and integrated services unique to those providers and organizations adept and efficient at specific types of care and services.

We do not support the concept of additional levels of "governance" and the overlaying and integrating this "governance" with the Boards of existing health care partners. It is impractical, duplicative and cumbersome. Specifically, we have an issue with overlaying "governance" from this council with the governing bodies and existing structures for planning, resource deployment and management integration in those organizations who would likely comprise such a village, either physical or virtual. Might an advisory council be a better description of the function of such a coordinating body, along with a clear outline of specific functions of this council that do NOT include "governance"?

Types of Complexes

Essential Care Complex (ECC) is a primary care office directed by a physician or health care practitioner. The office is a stand-alone physical location, in some instances may be co-located in a nursing home, EMS facility, or even a school. A mobile unit, such as a health mobile, may also be appropriate for smaller communities. The ECC will provide routine primary care and provides limited open access (walk-in) scheduling and some non-standard visits, such as group visits for managing some chronic conditions. The essential care complex could also act as the anchor for other initiatives planned by the Workgroup, including the mobile integrated health care that pairs EMS and community health workers. The ECCs will largely be new sites of care that will be established as part of the Demonstration.

RESPONSE: UMMS/ UM SRH support the designation of levels of care as described; they are essentially consistent with the service delivery plan and strategic plan of UM SRH. We do have the following questions about this recommendation:

1. **What do you envision the ongoing function of the Work Group in implementing the recommendations of the rural study?**
2. **UMMS/UM SRH support Essential Care Complexes being possible at existing sites of care as well as those established as part of the Demonstration.**

Advanced Primary Care Complex (APCC) is a continually operating primary care practice with capabilities to support specialists on a continual or intermittent basis. The APCC offers extended hours care, open access scheduling, and will support non face-to-face visits and group visits. The APC will have the capability to perform certain office-based surgical procedures when the relevant specialist is on site. The specialists that will be accessible at the site will be dependent on the needs of the community. Some will be co-located, such as behavioral health specialists and dentists and other medical and surgical specialists who operate on a time-allocated basis across multiple APCCs. Many APCCs already operate, but their services need to be enhanced or practice operations will need to be transformed. In some instances, new APCCs will need to be established through the Demonstration. Several existing FQHC sites are already delivering almost the entire range of services envisioned in the APCC.

RESPONSE: UMMS/ UM SRH support the designation of this level of care. This and other care complexes as described in this document mirror the strategies outlined in UM SRH Service Delivery Plan and strategic plan. UM SRH operates several successful facilities which would qualify as APCCs, with the greatest range of services as describes. These facilities exist in Easton, Queenstown and soon will be completed in Denton. We do have the following questions:

1. **Can you clarify what is meant by "continually operating primary care practice"? Do you mean a practice already in existence?**
2. **What do you envision will be needed to enhance or transform any existing APCCs?**

Advanced Ambulatory Care Complex (AACC) consists of a freestanding emergency department and, potentially, observation units with other outpatient services as appropriate. Behavioral health, substance abuse treatment centers, hospice and palliative care providers, medical and ambulatory surgical services could be located on the campus. The AACC would have a formal relationship with a parent health system and be integrated into MIEMSS. One AACC site in Queenstown now exists, although services may need to be expanded. Another AACC has been proposed in Cambridge, Maryland.

RESPONSE: UMMS/UM SRH support the designation of this level of care, consistent with its service delivery and strategic plans.

Special Rural Community Hospital (SRCH) is a small rural hospital consisting of an emergency department, an observation unit, and the capacity to provide inpatient and outpatient surgeries and to provide inpatient care. The SRCH possesses significant telehealth capability to support telehealth assessments and consults with patients outside the hospital and with clinicians at regional and academic medical centers. No SRCHs currently exist in Maryland, action by HSCRC will be required to enable creation of the SRCH.

RESPONSE: UMMS/UM SRH support the creation and sustainable funding of this designation as the number one priority of the rural workgroup recommendations. We request that the words be added to read "*enable creation and sustainable funding of the SRCH.*"

The Technology Component - PATIENT-CENTERED SUPPORT HUB – TECHNOLOGY TO INTEGRATE AND COORDINATE CARE

The Patient-Centered Support Hub enables seamless integration of the types of complexes that will recognized in the Community Health Complex Demonstration. Services envisioned to be available through the Patient Centered Support Hub are available through interoperable EHRs, services currently available through CRISP, or planned to be available via the CRISP Integrated Care Network (ICN). These technologies will support the coordination of care among health care providers; the integration of social and community services at the complexes; and support for patient and family educational and counseling services that will enable patient self-management and improved caregiver support.

The Patient Centered Support Hub, operating within the CRISP ICN, could enable the primary care physician to track patient needs and services provided to each enrollee to schedule educational/self-management services, government agency onsite services, and visiting subspecialty consultants.

RESPONSE: UMMS/ UM SRH support the recommendation and suggest that sustainable funding to support the Patient Centered Support Hub be included in the recommendation.

A Roadmap for standing up the Rural Community Complex

A. Strategic plan: create a vision, or sense of direction, with various phases and priorities.
Agree on intended outcomes

- **Phase 1: Planning**
  - **Market Feasibility** (Demographics and health status of population, geographic data, location, employment and industry trends, payer mix)
  - **Defining what type of facilities (or providers) are needed** (medical, dental, mental health, laboratory…) and what is already available
  - How to scale the Complex to community needs. The foundation is primary care**.**
- **Phase 2: Establish a Demonstration Complex**
  - **Set Performance Indicators/Benchmarks**
- **Phase 3: Evaluation of the Demonstration**
  - **(How do you measure "success" of the Demonstration?)**
- **Phase 4: Establish other Complexes**
  QUESTION: Who establishes and operates other complexes and with what sustainable funding?

B. Operational Plan

- **Assign responsibility for implementation – governance Council (see Recommendation #2 Rural Health Collaborative)**
  - Address interaction with other Boards or Councils
  - How do we encourage collaboration?
    RESPONSE: while we support the concept of the rural demonstration project and collaboration among various providers and organizations is

paramount, UMMS/UM SRH believe that there is no need for an overarching "governing body." The need to integrate the work of multiple other governing bodies with this process will be difficult with another "governing board." This issue was addressed in response to recommendation #1.

- **Staffing - Organizational Chart** (Board of Directors, management, administrative)
  RESPONSE: UMMS/UM SRH do not support the engagement of an additional "Board of Directors" and "governance" body with regard to these demonstration sites and complexes.
- **Define Informational Systems' Capacity (How do we link the providers by technology and to CRISP?)**

C. Financial Plan:

- **Identify Entity that will map resources/costs**
  - Identify Funding Sources (cash, grant funds, federal, state, local, other innovative thoughts for funding)
  - Identify Partnerships (within the community…Make the Complex community driven-)
    RESPONSE: UMMS/UM SRH support this concept but seek clarity on what is meant by "community-driven."
    Address Sustainability
    RESPONSE: UMMS/UM SRH agree that sustainability of the funding and expense structure is necessary for the initiation of new complexes and the sustaining of existing sites that meet these definitions.

Specific recommendations that will further the development of the Demonstration:

Increase Accessibility
1.a. Increase coordination of care through the use of care managers and patient navigators. Care managers help ensure that patients' needs and preferences for health services and information are met over time; especially at points of transition. Care managers may assess patient needs and goals, help create proactive care plans, link patients to community resources, and support patients' self-management goals. Patient navigators advocate for the patient, and help remove barriers to accessing timely care, as well as coordinate their care.

RESPONSE: UMMS/UM SRH agree that care coordination through care managers and patient navigators is essential to the future delivery of health care and have already begun implementing such personnel in our organization. Other health care and social services organizations have done so as well. We support the use of existing care managers and navigators and the expansion of these experts in the demonstration projects and beyond. We support efforts, many already underway, to ensure that all such staff across all organizations, are enabled in a virtual way to work together and share information and

collaborative approaches to health care. We seek clarity around who specifically will be the employer of those care managers and navigators working at a rural demonstration project?

1.b. Enhance dental health services to rural residents. Access to dental care is limited due to the available workforce and available coverage for vulnerable populations.

Where possible, dental care should be integrated with primary care and for populations with chronic conditions. The approach used by Choptank is an example of successful integration of dental services with primary care. Create opportunities for dental and dental hygiene students to participate in an elective during their clinical training for a rural health rotation.

RESPONSE: UMMS/UM SRH support the concept of integrating dental care with primary care where feasible.

1.c. Expand the availability of new telehealth and mobile capacity.

Implement new programs for telehealth that will support the development of rural health community complexes. Take to scale projects that have shown promise in telehealth and the Mobile Health Pilot Program.

- Increase broadband and "last mile" connectivity to include all sites of service, FQHCs, and Health Departments.
- Establish a stable funding level for telehealth consistent with recommendations in the 2014 Telehealth Work Group Report
- Direct the MHCC to develop methodologies for identifying practices and health care organizations suitable for using telehealth and the types of patients that respond to treatment through telehealth.

RESPONSE: UMMS/UM SRH support the expansion and funding of telehealth initiatives in the rural area. We seek clarity as to what is meant by "Mobile Health Pilot Program" (see above).

1.d. Expand or Enhance Community Paramedicine and/or Mobile Integrated Health Care. Sending paid EMTs, paramedics, mid-level healthcare professionals, or community health workers into the homes of patients can help with chronic disease management and education, or post-hospital discharge follow-up, to prevent hospital admissions or readmissions, and to improve patients' experience of care.

These health care workers can help patients navigate to destinations such as primary care, urgent care, dental care, mental health, or substance abuse treatment centers instead of emergency departments to avoid costly, unnecessary hospital visits. Identify a source for establishment and sustainability of the program.

RESPONSE: UMMS/UMSRH support the sustainable funding and development of these community based programs in the region, with sources of funding located outside of the hospital reimbursement system, perhaps from an payer/insurer state fund.

1.e. Create and Extend tax credits, loan, or grant opportunities for Practitioners to Practices in Rural Communities.

The General Assembly could establish tax incentives for medical, dental, and behavioral health care providers willing to practice in rural areas and for those who mentor students in these areas. Examples of these include the HEZ personal tax credit, HEZ hiring tax credits, tax credits for near-retirement providers who move to rural communities, and State-backed small business loans for practitioners to establish a practice in a rural community. The Department of Commerce could be encouraged to use its existing economic development funds to fund this program.

RESPONSE: UMMS/UM SRH support the expansion and streamlining of all such funds to encourage rural provider practice.

The following recommendation addresses economic impact:

1.f. Charge the Community Health Resources Commission with incubating pilot projects in rural communities to support of the Rural Health Community Complexes.

The General Assembly could create an additional funding source for local projects that are aimed at promoting health; these projects should be focused on rural communities and allow communities to meet their own needs.

Additional Draft Recommendations

Governance

RESPONSE: UMMS/ UM SRH do not support the concept of additional levels of "governance" and the overlaying and integrating this "governance" with the existing Boards of existing health care partners. We support the concepts of rural health demonstration projects and particularly of a rural health collaborative, described below and reflecting the strengthening and sustainable funding of the existing LHICs. However, as previously expressed, the use of the term "governance" and the expectation that the function of these entities as governed by a Board superseding other participating agency and organization Boards is not workable.

The following recommendation facilitates patient access to appropriate levels of care on a timely basis through cooperation and planning

2. Establish and Support a Rural Health Collaborative

Rural healthcare delivery faces different challenges due to distance, lack of transportation, inadequate number of available providers, as well as a high level of chronic conditions. Since the onset of healthcare transformation in 2010, more recognition has been given to the fact that the health status of a population is determined more by the social, behavioral, and environment domains than clinical medicine. Disadvantaged rural individuals with clinical and social needs can get lost trying to navigate disconnected services. However, health services planning rarely considers how to improve utilization of social, behavioral, and environmental services for the most vulnerable populations.

Rural counties often have sparse, but widely distributed populations. Many rural residents have many of the same health issues and needs. Often, the most common problems are chronic conditions. Service agencies in rural areas operate with limited funding and are forced to share staff across county jurisdictions to maximize services and efficiencies. A growing need exists for regional collaboration in rural areas as a method of improving the health of rural residents and maximizing current and future resources for many service agencies. In rural areas that have a single hospital system serving multiple counties, collaboration between the public and private health sectors in these regions becomes even more beneficial for clients trying to navigate and coordinate services.

A Rural Health Collaborative (RHC) for counties served by the same hospital system could benefit patients through better integrated and accessible services; the hospital system with one entity to help facilitate implementation of plans and services; and county health and social agencies in maximizing resources for better utilization of existing services. A Rural Health Collaborative may be organized in each of the rural regions: Mid Shore, Lower Eastern Shore, Southern Maryland, and Western Maryland; and may serve as the governing body for the proposed Rural Community Health Complex.

RESPONSE: UMMS/UM SRH support the demonstration project. The title of this section says "Establish and Support a Rural Health Collaborative." Per the paragraph just above, won't there be such collaboratives established in all such rural regions of the State?

Additionally, while we support the concept of the rural health collaborative, we do not support that the rural health collaborative should function as the "governing body" of the rural community health complex, as previously detailed in our response. The strength of the rural health collaborative will be in its ability to expand and support the work of the existing regional LHICs under the Department of Health.

An RHC could facilitate the following:

- Data collection and analysis for Community Needs Assessments that roll into a Regional Health and Social Needs Assessment

  RESPONSE: We support the LHICs being accountable for conducting the community health needs assessments for their regions, provided this function is no longer required for hospitals to comply with HSCRC regulations.

- Identifying needs for the region but also the pockets of special needs within the counties
- Developing strategic directions for improvement of health in the region
- Better integration of clinical health needs with social, behavioral, and environmental needs that impact health and clinical outcomes
- Collaboration in seeking grant funds that are more likely won with a bigger service population
- Collaboration in sharing services and staff across jurisdictional lines for economies of scale
- Potential services created with pooling of resources
- Integrating work of the Local Health Improvement Coalitions into broader regional initiatives
  RESPONSE: We seek clarity about what "broader regional issues" means—issues that cut across regions, or issues that are broader than health care?

This Rural Health Collaborative will have a Director to work with the key county representatives to facilitate planning, meetings, data collection, examples of proven strategies for rural health improvement, and distribution of information. Other staff or contracted services will be at the discretion of the RHC.

The following recommendations expand and attract primary care providers to rural areas:

3. Establish a Rural Scholarship Program for Medical Students and Other Healthcare Professionals willing to practice in rural Maryland

The General Assembly should establish a rural scholarship for medical, dental, behavioral and other health care professional students willing to practice in rural areas of Maryland.

Geographic coverage
Maryland Rural Regions: Mid Shore, Lower Eastern Shore, Southern Maryland, and Western Maryland

Eligibility
Eligibility would be open to all students admitted to health services programs in the State who agree to serve in rural areas of Maryland upon graduation. The scholarship program would be open to all students admitted to recognized programs in public and private higher education institutions, but a preference would be given to students that originated from a specific rural region and committed to return to that region. The Rural Scholarship Program should be developed so that any funds awarded do not constitute taxable income under Maryland law and to the extent possible under federal income tax law.

Preference is given to students who meet at least 2 of the following requirements:

- The student has received a high school diploma, or its equivalent, in Maryland

- The legal residence of the student's parent(s) or legal guardian(s) is in Maryland
- The student has a substantial connection to the state of Maryland and at least one year of residence in Maryland for purposes other than education.

Funding sources
Funds would be appropriated by the Maryland General Assembly. Regions would be required to match State funds on a one to one basis to help with tuition, required fees, and other educational and living expenses.
RESPONSE: UMMS/UM SRH support the identified need for funding these initiatives but seek clarity on how regions will identify matching funds for State funds.

Amount of funding
The number of awards would be based on level of practice and funds available.

Recipients of the scholarship would be required to fulfill a minimum four-year service commitment. Students awarded a scholarship would have a specified amount written off for each year of service. Repayment formulas would be back-loaded to incent students for fulfilling their commitments.

A State non-lapsing fund would be established in statute to enable rollover of funds not expended in a fiscal year.

State commitments would be set at $500,000.

Response: UMMS/UM SRH support this recommendation.

4. Incentivize medical students and residents to practice in rural communities

4.a. Identify sustainable funding for a Primary Care Track program that enables medical students to work alongside family medicine, general internal medicine, or pediatric physicians that practice in underserved areas.

The focus of the University of Maryland School of Medicine (UMSOM) Primary Care Track is to introduce students to primary care role models early in medical school and to offer a longitudinal experience in primary care in rural and urban underserved communities to interested students. The goal is to increase the number of UMSOM students who choose careers in primary care by: 1) connecting first year students with primary care physicians in urban as well as rural underserved communities and creating the opportunity for longitudinal mentorship and clinical experiences with them throughout their four years of graduate studies; 2) educating them early about important topics in primary care and community health; and 3) fostering a greater appreciation for the challenges and rewards of caring for the underserved in Maryland. This four year elective offering culminates in each student's participation in Primary Care Day, where the senior students serve as role models for their junior colleagues.

What's needed:

- Effort on the part of the State to encourage JHUSOM to join UMSOM in participating.
- Modest funding for;
    - Preceptors that participate in the program.
    - Housing allowance for medical students that participate in the program
    - AHECs that, in collaboration with the Departments at UMSOM and JHUSOM, would sponsor students and oversee the program
    - Faculty and school based coordination support

***Response*: UMMS/UM SRH generally support this recommendation.**

4.b. Establish Rural Primary Care Residencies

Research suggests that residents who train in rural areas and whose training emphasizes services necessary for rural practice are more likely to practice in rural areas after their residencies end. Residency programs in rural areas may expose residents to the benefits and challenges of practicing in a rural area and prepare residents to practice rural primary care medicine.

Primary care residency programs in rural hospitals should be aligned to meet the needs of rural populations and support the continuation of rural practices for those in private practice. Federally Qualified Health Centers may be included in the residency experience, giving residents the opportunity to work with a higher volume of diverse and underserved patients. Residents may gain a deeper knowledge of the social determinants of health and explore potential remedies that address these issues on a local, regional, and national scale.

Incentives for Rural Residency

- Active support by the community
- Employment opportunities for the physician's spouse
- Free on the job CEU programs for clinicians in rural areas
- Affordable housing

Response: UMMS/ UM SRH generally support this recommendation

4.c. Establish a Rural Specialty Care Residency Rotation

The inability to recruit general surgeons, obstetricians, anesthesiologists and certain other specialists are important contributors to the failure of many rural hospitals. Establishing specialty care residency rotations in rural hospitals could ease the challenge of attracting these specialists to rural communities. All surgical and medical specialty residency programs in Maryland are located in Baltimore City and Baltimore County hospitals. The Baltimore hospitals provide valuable training in mostly academic teaching environments and the clinical staff are excellent. These settings expose residents to varied and complex clinical situations. Often, these are the exact experiences that medical students seek in residency programs. Limiting the

training setting to these environments undervalues future practice in smaller hospitals and rural communities. Exclusive training in these settings tends to incentivize preferences for types of future employment in medical and surgical subspecialties. The concentration of training programs in Baltimore may also contribute to Maryland ranking 42nd (37.5%) of all states in retaining medical and surgical residents trained in State. Working as a general surgeon in an under-resourced setting might not generate as much attention as being a surgical subspecialist in a large urban or academic setting, but physicians working in under-served and rural areas often have high levels of job satisfaction and fulfillment that far exceed their colleagues in other settings. If residents are never offered the more diverse experiences, chances for selecting those clinical settings are low.

Establishing a rural medical or surgical residency program could be challenging. Rotating medical and surgical residents through rural hospitals offers the potential to expose residents to the challenges and benefits of delivering specialty and surgical care in rural communities. To establish these rotations, Maryland may need waivers from ACGME that requires residents to work at sites less than 50 miles from the sponsoring hospital. Most of the eligible rural hospitals are more than 50 miles from the Baltimore hospitals that have established residency programs. Rural hospitals would also need additional funding to support surgical and medical specialty residents. Making any GME funding available through enhanced hospitals rates could challenge the Global Budget Revenue limits agreed to under the current All Payer Model and Total Cost of Care Model (TCoC) beginning in 2019. One possible solution would be to offset any GME funding provided to a rural hospital with small reductions in GME at the sponsoring hospitals in Baltimore. Testing the principle of allowing funding to follow the resident could be an additional benefit of this recommendation. Other requirements for a rural specialty resident rotation parallel the program requirements for Recommendation 4.a., specifically, housing support from the rural community.

RESPONSE: UMMS/UM SRH agree that rural residency programs could provide long term benefits to rural communities. Funding under existing GMEs could prove challenging. Likewise, housing support from the rural community should be defined as in coordination with AHECs, to avoid the challenge of county by county coordination.

5. Streamline and Expand the Maryland Loan Assistance Repayment Program (M-LARP)

The General Assembly should streamline the management of the State LARP by centralizing oversight of the program in either the Maryland Higher Education Commission or the Maryland Department of Health.

Recommendations

- Place an emphasis on loan assistance repayment for primary care providers in rural areas.

- Increase funding for M-LARP beyond the current $400,000 and identify additional sources of funding.
  RESPONSE: UMMS/UM SRH support streamlining and expansion of M-LARP.

6. *Realign the prioritization of the J-1 Visa program*

The Maryland J-1 Visa Waiver Program offers a J-1 Visa waiver to foreign physicians who commit to serving for 3 years in an underserved area of Maryland, waiving the foreign medical residency requirement, and allowing them to remain in the United States. The program is intended to provide physician services in areas that typically have difficulty attracting and retaining physicians. The Maryland program should:

- Prioritize applicants who are willing to work in rural HPSAs and medically underserved areas for a limited number of state slots.
- Encourage and assist communities where J-1 visa recipients are placed; including:
  - Creating a welcoming environment and developing programs to support visa recipients and their families,
  - Helping the spouse of a visa recipient find employment,
  - Improving cultural competency of the community

  RESPONSE: UMMS/UM SRH support.

7. Develop and fund additional nurse practitioner and physician assistant programs in rural colleges and universities

The need for efficient primary care in rural Maryland areas is a growing concern due to changing demographic trends (such as an aging population) and the shortage of primary care physicians. One approach to meeting the increased demand for primary care services is the use of non-physician practitioners such as nurse practitioners and physician assistants. In addition, these health care professionals can help increase care coordination to reduce hospitalizations and re-hospitalizations for elderly patients and others with chronic health conditions, resulting in decreased health care costs and better health outcomes.

Programs should actively recruit individuals from rural areas for entry into the program. The Advanced Education Nursing Traineeship Program (HRSA) provides funding to schools of nursing for student support for tuition, books, fees and living expenses needed by RNs to become NPs.

RESPONSE: UMMS/UM SRH support.

The following recommendation enhances and integrates behavioral health services:

8. Enhance Behavioral Health and Substance Abuse Services in the Community

- Enhancement of behavioral health services in the community through mobile integrated healthcare, telehealth, and enhancement of Assertive Community Treatment (ACT) Teams can reduce mental illness, improve the well-being of rural communities, and lower the total costs of care by eliminating costly emergency and hospital care. Health care organizations should be encouraged to breakdown the invisible and very real stigma associated with behavioral health conditions by establishing education programs for their staff.
- Recognize that behavioral health diseases deserve to be treated with as much compassion as physical health conditions.
- Existing infrastructure and programs that are working, but underfunded, should be favored before new programs are launched.
- Identify statutory and regulatory barriers to the establishment of the new programs.

The Workgroup recommends that to the extent funding is available:

Expand the Eastern Shore Crisis Response System in accordance with recommendations from the Behavioral Health Advisory Committee and the MD BH Crisis System law.

  - Increased funding and staffing for the Eastern Shore Operations Call Center (HELPLINE).
  - Increased funding for Mobile Crisis Teams to ensure 24/7 operations of the four teams.
  - Work with hospitals to expand crisis beds in acute general hospitals.

- Consider expanding the Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP) to adult primary care. http://www.mdbhipp.org/
- Work with payers to ensure adequate provider networks in rural regions for those privately insured.
- Expand the provision of Assertive Community Treatment (ACT) mobile treatment teams to provide community-based comprehensive care to those most difficult to engage in transition "office-based" systems of care.
- Increase the availability of "on-demand" or immediate access to all levels of Substance Use Disorders treatment, especially withdrawal management and inpatient care for those being treated for substance related overdose.
- Increase availability and utilization of Certified Peer Recovery Support Specialists within the Behavioral Health Systems of Care regardless of insurance coverage type.
- Streamline the licensing of both individual behavioral health providers and behavioral health provider organizations to ensure financial solvency, support the State's economic goals, and increase access to care.
- Encourage payers to accelerate credentialing of behavioral health providers.
- Align rural area health education center efforts, DLLR and Workforce Investment Board grant funding, and loan forgiveness programs in the BH professional area.
- Expand the allowable and reimbursable use of telehealth to ensure access to Behavioral health specialty care in rural areas to overcome transportation and workforce barriers.

RESPONSE: UMMS/UM SRH support the need for expansion of crisis response services, transitional care sites and peer recovery specialists as a support structure necessary for behavioral health and addictions care in the region.

The following recommendation provides additional opportunities for care in the home

9. Consider the Recommendations of the Workgroup on Workforce Development for Community Health Workers and Foster the Development of the Community Health Worker Programs at Maryland Community Colleges and AHECs.

Community Health workers are frontline public health professionals who are also trusted members in their communities and have an unusually close understanding of the communities they serve. During its 2014 legislative session the General Assembly established the Workgroup on Workforce Development for Community Health Workers. That workgroup delivered its recommendations in June 2015. Stakeholders should be brought back together to revisit the recommendations of the workgroup on Workforce Development for Community Health Workers

Potential roles of the CHW:

- Serving as a liaison between communities, individuals, and coordinated health care organizations.
- Providing evidence based health guidance and social assistance to community residents.
- Enhancing community residents' ability to effectively communicate with health care providers.
- Providing culturally and linguistically appropriate health education.
- Advocating for individual and community health equity.
- Providing care, support, follow-up, and education in community settings such as homes and neighborhoods.
- Identifying and addressing issues that create barriers to care for specific individuals.
- Providing referral and follow-up services or otherwise coordination of human services options.
- Proactively identifying and referring individuals in federal, state, private or non-profit health and human services programs.
- Integrating with a patient's care team to support progress in care planning and overall patient wellness.

Certification should be considered to meet future professional validation.

RESPONSE: UMMS/ UM SRH support the need for the expanded training and use of Community Health Workers and agree that the previous study recommendations be

implemented, with special attention to keeping the costs of education for CHWs at a manageable level so as not to deter pursuit of the field.

The following recommendations improve access to specialty services at the local level:

10. Create a special hospital designation for Rural Communities

The program should be established under HSCRC's broad authority to establish reasonable reimbursement for Maryland hospitals. To qualify, the hospital must specify concrete goals and plans for implementing the goals. The plans could include initiatives for improving the quality of care, establishing expanded access to advanced primary care and thereby decreasing the number of avoidable admissions, readmissions, and transfers. Specific requirements:

a. Located in a federally designated rural jurisdiction (Kent and Garrett) or qualify in a county-wide medically underserved/HPSA jurisdiction
b. Located 35 miles or more from the nearest general acute care hospital or 15 miles from another general acute care hospital where more than 50 percent of the distance is traveled on secondary roads
c. Have an ALOS of 4.0 or less
d. Furnish 24-hour emergency care services 7 days a week
e. The hospital qualifies for a special designated rural hospital adjustment under its global budget if the hospital establishes an HSCRC-approved Special Rural Hospital Program.
    i. A strategy for maintaining financial viability by maintaining/improving its financial situation, both in terms of current programs and the proposed demonstration.
    ii. Explain how the additional adjustment will assist the hospital to respond to financial, demographic, and health care delivery factors that pose a risk to ongoing operations.
    iii. Describe the specific projects for which it will use additional GBR and how these funds would benefit vulnerable populations in the hospital's service area. Goals could include increasing access to care and provision of additional services, but they may also include transitioning to alternative delivery and payment models, such as an FMF as appropriate or partnering with an ACO or MPCP.
    iv. Hospital would describe how it would work with other health care providers and facilities to serve the population in the hospital's service area and explain how any enhancements provided through the additional GBR would contribute to the population's health.
f. The program would last for five years and would be renewable by agreement of HSCRC and the hospital.

RESPONSE: For UMMS/UM SRH, this designation is priority number one to come from the rural study. We heartily support the creation of this designation and sustainable funding for same through hospital rate setting, acknowledging the inherent issues of quality, cost and financial sustainability in such settings.

11. Expand non-Medicaid and Non-Emergency Transportation

11.a. The State should promote the use of innovative approaches to non-emergent transportation in rural areas where transportation deficits are the most acute. Explore the use of commercial transport such as Uber and Lyft. These approaches could include seeking a health department interested in establishing a demonstration to test the feasibility of establishing a transportation service or promoting the use of ride sharing technology.
RESPONSE: UMMS/ UM SRH support. Please note additional suggestions in attached listing

11.b. ***The Department of Health, in consultation with the Maryland Dept. of Transportation, should develop standards for non-emergency programs based on best practices for these programs.*** The Rural Health Delivery Workgroup found that reimbursement for non-emergency medical transportation is extremely uneven. Greater effort needs to be placed on equitable funding for non-emergency medical transport. Both residents and local governments would benefit from this standardization. Regulatory and or statutory changes may be necessary.
RESPONSE: UMMS/UM SRH support. Note additional suggestions in attached listing.

12. Address health needs of the immigrant population and elderly populations

The immigrant and elderly populations in the Mid-Eastern Shore and other rural areas of Maryland are growing. These populations may be at increased risk for poor physical and mental health because of inadequate health care due to:

- Lack of transportation
- Inability to pay for services
- Poor health literacy
- Lack of culturally competent health care professionals
- Complex paperwork to gain access to services
- Immigration status and the need for documentation to get services
- Limited English proficiency and the lack of translation services

In order to improve the health status of vulnerable populations in rural areas and address the concerns of these populations:

-Expand and strengthen the safety net infrastructure
-Provide access to preventive care and education
-Increase the use of patient navigators and care managers -
-Encourage the development of programs to increase Culturally and Linguistically appropriate Services (CLAS)

RESPONSE: UMMS/UM SRH support.

UMMS/UM SRH PRIORITIZATION OF RURAL STUDY RECOMMENDATIONS

AND CROSS-REFERENCE TO RURAL STUDY WORKGROUP DRAFT RECOMMENDATIONS

UMMS/SRH Prioritized Critical Need		UMMS/SRH Recommendations	Corresponding Rural Study Group Recommendation
#1	**Facilities Investments/Access to capital**	• CON replacement hospital Easton • CON exemption for FMF conversion Cambridge • HSCRC to provide sufficient funding in rates for Easton and maintain regulated rates for Cambridge, to cover full debt service for these capital facility projects • New Rural Community Access Hospital designation (mild-moderate inpatient care ≤4 days, inpatient/outpatient surgical capacity to be defined) Chestertown • Add observation beds to QA Freestanding Emergency Center to become FMF	**Pilot projects that support access to care** **Create a special hospital designation for vulnerable rural communities**
#2	Competitive Environment	• Acknowledge the disruptive and threatening nature of urban health system competition in the rural environment • Develop disincentives for competition **and** incentives to support sustainability for rural hospitals affected by competition	N/A

	UMMS/SRH Prioritized Critical Need	UMMS/SRH Recommendations	Corresponding Rural Study Group Recommendation
#3	Provider Recruitment and Retention/Workforce Development	• Student Debt mitigation/loan forgiveness programs built up and streamlined, with earmarks for rural students • J-1 Visa program with rural slots guaranteed • Support rural primary care residencies; require rural residency obligation in medical school • State subsidies for practice support in rural areas • Increase reimbursement for primary care in rural areas • Tuition subsidies • Loan forgiveness for rural health care employment commitment	**Use of Care Managers** **Tax credits, loans and grant opportunities for rural providers** **Establish and fund rural scholarship programs** **Sustainable funding for primary care track program in School of Medicine** **Modernize and expand LARP** **Realign priorities of J-1 visa program** **Develop/Fund more NP/PA programs in rural higher education** **Expand peer support in behavioral health** **Grow and implement Community Health Workers in vulnerable rural communities**

	UMMS/SRH Prioritized Critical Need	UMMS/SRH Recommendations	Corresponding Rural Study Group Recommendation
#4	**Transportation**	• Wellmobile: support units operated locally and financially support a sustainable deployment of Governors Wellmobile with UMSON staff to key rural locations • MICH: sustainable funding support for expanding and developing programs in rural areas • Explore Medical transport network w/voucher system • Consider tax incentives to auto dealers to support rural medical transportation • State-led initiative to leverage existing Federal and State resources	**Expand, enhance and sustainably fund Mobile Integrated Health Care (MICH) in vulnerable rural communities** **Special hospital designation for rural communities** **Expand non-Medicaid and non-emergency transportation with innovative funding** **Address health needs of elderly and immigrant populations**
#5	**Telemedicine**	• Expand broadband access to homes • Firm up payment models for physicians using telemedicine • Support technology at institution and patient/home level	**Expand availability of telehealth and mobile capacity** **Address health needs of elderly and immigrant populations**

	UMMS/SRH Prioritized Critical Need	UMMS/SRH Recommendations	Corresponding Rural Study Group Recommendation
#6	New models of care	• Effective coordination and resources for rural behavioral health and addictions treatment programs • Funding for rural transitional housing and home care model for addiction treatment • Mobile Integrated Health Care sustainably funded by State and local jurisdictions in rural areas • Change the 72 hour rule for inpatient requirement prior to skilled nursing, rehabilitation and home care admission; enable FMF, observation and home admission to skilled nursing, rehabilitation or home care.	**Enhance behavioral health and substance abuse services in the communities** **Expand, enhance and sustainably fund Mobile Integrated Health Care (MICH) in vulnerable rural communities** **Expand and fund pilot project opportunities** **Expand availability of telehealth and mobile capacity** **Special hospital designation for rural communities**
#7	Rural Health Planning	• Strengthen/focus local regional health planning • Population health improvement/coordination of care • Funding for rural initiatives/collaboratives that come out of that local health improvement planning • Enable rural independent providers to collaborate in care under "safe harbor," similar to what is enabled through FQHCs	Use of care managers **Expand and fund pilot project opportunities** **Expand, enhance and sustainably fund Mobile Integrated Health Care (MICH) in vulnerable rural communities** **Establish and support rural health collaboratives** **Dental services expand in collaboration with primary care**